

HOME HEALTH PPS

Frequently Asked Questions

CONSOLIDATED BILLING

- What's In?
- What's Out?

CONSOLIDATED BILLING

- IN
 - Routine and non-routine medical supplies
 - Therapy services previously unbundled and billed to Part B
 - Osteoporosis drugs
- Out
 - Durable medical equipment

I am still confused regarding the responsibilities of the HHA to provide medical supplies.

Here is my example - A quadriplegic who performs intermittent catheterization 6 times/day. He/she develops a decubitus ulcer which requires home health services for wound care. Under PPS, I understand the the wound supplies would be included in the PPS episodic rate. What about the catheter supplies that are unrelated to the HHA "plan of care" i.e. wound care?

- Section 1895(b)(1) of the Social Security Act
 - all services covered and paid on reasonable cost basis including medical supplies are to be paid prospectively

- Section 1842(b)(6)(F) of the Act
 - Consolidated billing requirements
 - Routine and non-routine medical supplies furnished while patient is under plan of care are included in the episode payment

Does agency discharge with goals met negate the agency's financial responsibility for Part B supplies and services that the patient needs/uses after the agency discharge but before the end of the 60-day episode?

Yes. The home health agency is responsible for for Part B supplies and services only while the patient is under the plan of care. Once the patient is discharged, the agency is no longer responsible for providing those Part B supplies and services.

How should a rehab provider handle the following situation? In personal care homes or assisted living facilities you will find rehab providers who lease space and provide outpatient (Medicare B) physical therapy, occupational therapy and speech- language pathology services to Medicare beneficiaries. These same Medicare beneficiaries are receiving home health nursing. The patient is truly homebound, but the onsite arrangement leads to the beneficiary choosing outpatient therapy services and home health nursing services. How will this fair when in home health the OASIS and HHRG dictates a need for home health rehab services?

While the patient is receiving services from the home health agency and is under a home health a plan of care, the home health agency must provide the therapy services either directly or under arrangement. The rehab provider may provide the services under arrangement to the home health agency and will seek reimbursement from the home health agency as the home health agency will receive the payment for the episode.

REQUEST FOR ANTICIPATED PAYMENT (RAP)

- Increases cash flow to home health agency
- Based on physician's verbal orders
- Not subject to 14-day payment floor

Does the verbal order for the Request for Anticipated Payment (RAP) only have to be written and sent to the physician for signature or does the verbal order need to be signed by the physician before submission of the initial episode's RAP?

The verbal order for the RAP only has to be written and sent to the physician before submission of the RAP. The verbal order must be signed prior to submission of the final claim.

Does the first billable
visit have to be rendered
before the RAP may be
submitted?

In all cases, without exception,
a service must be delivered
before a RAP may be
submitted.

Does the OASIS have to be locked and transmitted before the RAP may be submitted?

No. The OASIS does not have to be locked AND transmitted. The OASIS only has to be locked for transmission but not actually transmitted before the RAP may be submitted.

If the physician orders 4 or fewer visits, I know the episode will be paid the LUPA amount. Can I still submit a RAP?

Yes. The agency has the option of submitting either a LUPA claim with no corresponding RAP or a RAP which would require a payment adjustment after the agency submits the claim containing the actual number of visits provided.

Can the RAP and the final claim for the same episode be submitted for the same patient in the same submission file?

Yes. But there is a risk that the final claim might be processed before the RAP is processed. If this happens, the final claim would be returned to the provider.

GRACE PERIOD

- One month grace period for
 - OASIS assessments
 - Plan of care certification requirements

Will all patients under a home health plan of care on October 1, 2000 have a start of care date of October 1, 2000? What if there is no billable visit on October 1?

All patient's start of care date will be October 1, 2000 regardless of whether or not a billable visit occurs on October 1. This is a one time exception associated with HH PPS implementation.

Describe what is required by the “statistical break” in services -- specifically, how to document pre-PPS physician ordered services and post-PPS physician ordered services in the plan of care.

The home health agency must document the physician orders that are associated with services rendered under cost-based reimbursement up to and including September 30, 2000. It must also document the physician orders associated with the patient's first episode under the new prospective payment system for services rendered on or after October 1, 2000.

For patients already under an established plan of care as of September 1, 2000, will they need 2 plans of care during September?

No, they will need only one plan of care. Home health agencies have the option to take advantage of the one-time, up to 90 days, grace period governing the physician certification of the plan of care for established home health patients.

The OASIS does not appear to require obvious responses to “GOALS MET” or “Transfer to another Home Health Agency” on discharge, which could result in a PEP. Does an “NA” response to M0855 indicate a possible PEP? If not, what are the indicators HCFA would use to recognize a PEP (other than 06 on the final claim)?

The OASIS does not indicate a PEP. HCFA will recognize a PEP by a 06 in the patient status field on a claim, “B” or “C” on the source of admission of a RAP (PEP would be to previous episode) or the result of an automatic adjustment in Medicare systems when there is an overlap between episodes for a single beneficiary.

Regarding the grace period, for any established home health patient in August, can the August OASIS be done any time in September for grouping purposes OR for established OASIS patients that are under a plan of care in August, can their next scheduled September OASIS be done any time in September?

Any established home health patient who has a follow-up assessment due in August may delay that assessment until any time in September and do the OASIS B-1 (8/2000) for grouping purposes. Also, for established patients in September, they can use the start of care/resumption of care or appropriate follow-up OASIS to group patients for case mix purposes. All necessary items for case mix must be used (for the OASIS B-1 (8/2000)).

For established home health beneficiaries, will providers be able to certify patients at varying periods of time up to a maximum of 90 days (with pre- and post- PPS physician ordered services); or is it to be understood that all established home health beneficiaries will have a certification period ending on November 29, 2000?

Established home care patients certified Sept. 1 through Sept. 30, 2000 will have a 1st episode that covers Oct. 1 through Nov. 29, 2000 with an end date of Nov. 29 unless there is an applicable adjustment (e.g. PEP, transfer).

Since licensed staff other than the supervisor/providing professional (e.g. intake staff) take verbal orders and must sign and date those orders, will countersignature of such orders by the supervisor/providing professional suffice to meet the “attestation” reference in the final rule?

Yes. A countersignature
of the
supervisor/providing
professional will suffice
to meet that requirement.

Is there a specified period of time between a discharge and the start of care with a new episode to qualify for the 60/40 split? For example, if the patient is in the hospital on days 58 through 62, the patient must be discharged from home health. The patient returns home on day 63 and the home health agency re-admits on day 64. Will the new episode be given a 60/40 split percentage payment?

Yes. There is no specific requirement for the length between episodes. Once there is any gap between episodes, the new RAP should be submitted as an initial episode with a 60/40 split payment.

If a patient transfers to a hospice during an episode, does the agency get a PEP or a full payment? What if the hospice and home health agency are under common ownership?

If a patient elects hospice before the end of the episode and the patient did not experience an intervening event of discharge and return to the same HHA, or transfer to another HHA during an open 60-day episode prior to the hospice election, the HHA receives a full episode payment for that patient. Upon hospice election, the beneficiary is no longer eligible for the home health benefit. The common ownership restriction for the PEP adjustment applies only to the relationship between two HHAs providing covered home health services to a home health eligible beneficiary.